

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236

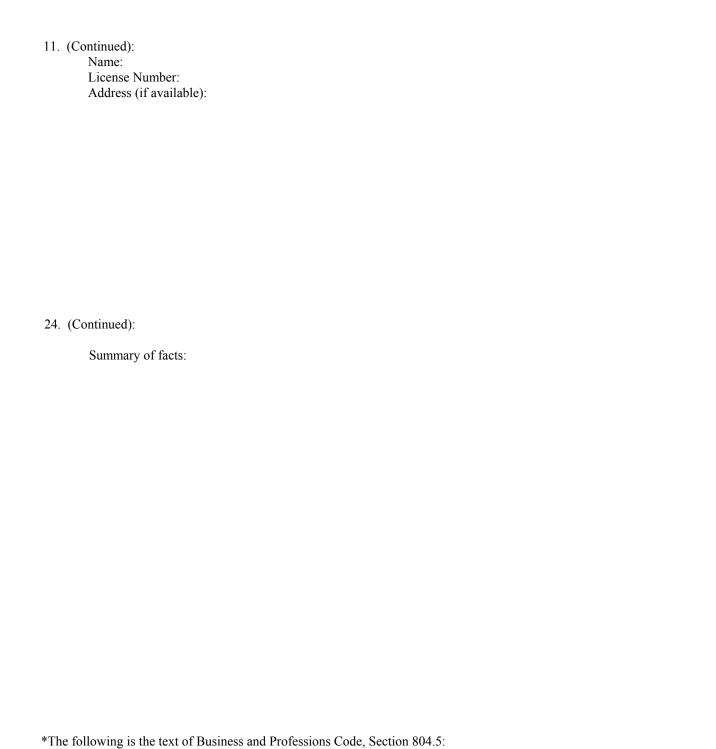


REPORT OF

SETTLEMENT, JUDGMENT OR ARBITRATION AWARD Required by Section 801, 801.1, 802, 803.2 Calif. Business and Professions Code

PLEASE CHECK THE APPROPRIATE BOX:

□ Section 801 □ Section 801.1	(Insurance Company) (State or Local Government)	□ Section 8 □ Section 8 □		(Self-insured) (Employer-Prof. Corp., gro	oup practice, health care facility or clinic)
		INSURER/F	PUBLI	C ENTITY:		
1. Name 3. Address			2. Telephone			
		PHYSICIA	AN/PR	OVIDER:		
4. Name			5. License Number Specialty/subspecialty			
6. Address(es)						
8. Counsel's Name 10. Address			7. Policy Number9. Counsel's Phone Number			
NOTE: On reverse, enter full name(s) of other physicians or health care providers who were claimed or alleged to have acted improperly, Whether or not such persons were named as defendants, or whether or not any recovery or judgment was against such persons. If any monies were paid on behalf of those listed, please indicate the amount.						
		PLAINTII	FF/CL	AIMANT:		
12. Name 13. Address(es) Business Residence 14. Hospital Name and Address 15. Incident Date 17. Patient Name 19. Patient Date of Birth 21. Counsel's Name 23. Address			16. Date of Admittance 18. Hospital Chart Number 20. Deceased □ Yes □ No 22. Counsel's Phone Number			
Enter on reverse, a description or summary of the facts upon which each claim, charge or judgment rested including date of occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of Unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent documents which contain this information may be attached instead.						
25. Case Resulted in: (Check one) □ Settlement □ Judgment □ Arbitration Award 26. Date Resolve			_ I	Total Amount of Award:	28. Total Paid on Behalf of Physician	:
29. Name and Location of Court/Arbitrator:			30. Filiı	ng Date:	31. Docket Number:	
within this report a	and any attachments is true and	l correct.			wledge the information provided Typed) Date	
Signature of Responsible Agent or Insurer Name and Title (Printed or Typed) Date						



The Medical Board of California may request a licensee, health care facility, self-insured governmental agency, or professional liability insurer that is required pursuant to Section 804 to comply with a request for medical records of a patient, or a copy of any depositions in a case that discusses the care, treatment or medical condition of a person, to permit representatives of the board to obtain copies of these records from the custodians of these records subject to reasonable costs to be paid by the Medical Board of California.